Health Policy Commission

Advisory Council Meeting

April 16, 2014

Agenda

- Executive Director's Report
- 2013 Cost Trends Report
- CHART Investment Program
- Discussion
- Schedule of Next Advisory Council Meeting (July 16, 2014)

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2013: A year in review

The first public meeting of the Health Policy Commission was held on November 17, 2012. Since then, the HPC moved quickly to meet its statutory requirements.

Public Meetings

- Held 10 board meetings in 2013 and 4 in 2014
- Held 31 committee meetings in 2013 and 8 in 2014
- Held 3 advisory council meetings
- *Generated significant public attendance at all meetings*

Implementation Milestones

- Established the health care cost growth benchmark for calendar years 2013 and 2014 (3.6%).
- Published a report on consumer-driven health plans in March 2013.
- Issued guidance on the prohibition of mandatory nurse overtime.
- Transferred the Office of Patient Protection from the Department of Public Health in April 2013.
- Administered the first year's collection ($72M) of a one-time $225M industry assessment. The second year's collection is occurring now.
- Began receiving and reviewing providers' notices of material change. Initiated four cost and market impact reviews and released findings from the first cost and market impact review (CMIR) report.
- Initiated the first analysis of the all-payer claims database (APCD) to inform cost trends work.
- Held the HPC's first annual hearing on health care cost trends and its issued first annual cost trends report.
- Released $10M in funds from Phase 1 of the Community Hospital Acceleration, Revitalization, Transformation (CHART) Investment Program.
- Approved Office of Patient Protection (OPP) regulations to ensure compliance with the federal Affordable Care Act and new state law.

HPC 2014 Activities: Q1 and Q2

January – June 2014

CHART

- Finalize Contracts for CHART Phase 1 Grants and Establish an Evaluation Framework
- Develop Framework for CHART Phase 2 and Release Phase 2 RFR

Market Performance

- Issue Final Report on CMIR for Partners/South Shore/Harbor Transaction
- Develop and Release Proposed Market Regulations for Public Comment
- Issue Preliminary and Final Report on CMIR for Lahey/Winchester
- Issue Preliminary and Final Report on CMIR for Partners/Hallmark

Office of Patient Protection

- Finalize Regulations for the Office of Patient Protection to Comply with the ACA

Cost Trends

- Establish Health Care Cost Growth Benchmark for 2015
- Develop Cost Trends Research Agenda for 2014
- Prepare Summer Supplemental Cost Trends Report
- Planning for Annual Cost Trends Hearing

Care Delivery

- Finalize Program Design and Certification Standards for the PCMH Demonstration Project
- Finalize Regulation and Data Submission Manual for Registration of Provider Organizations

Behavioral Health Integration

- Advance behavioral health integration across HPC activities, including PCHM/ACO care delivery models, CHART investments, and research agenda
- Support and monitor other state activities including public health planning, public payer commission, and new parity requirements

2014 Behavioral Health Agenda

	Planned HPC activities for 2014
Promoting clinical standards through accountable care models	▪ The development of behavioral health (BH) criteria and standards to be included in the PCMH program (joint effort of the CDPST and QIPP committees); the development of evaluation and measurement metrics for BH in the PCHM setting; and the engagement of payers on payment support for BH services. Focus will shift to developing the ACO certification program in Q3 and Q4 of 2014.
Promoting clinical models through investment	▪ Providing CHART awardees a number of capacity-building opportunities through training, leadership assessment, and technical assistance; overseeing and evaluating Phase One projects, including the dissemination of lessons learned and best practices; developing and implementing the Phase Two CHART investment opportunity in which we plan to provide significant, strategic investments in targeted areas of HPC focus.
Research, evaluation, and analysis	▪ Extend analysis of high-need patients to the MassHealth population; coordinate with the work of the Public Payer Commission as it pertains to behavioral health; other on-going research and analysis in areas of interest to the Commission Board; and monitor research of others in this area.
Capacity and needs assessment (Health planning)	▪ On-going participation of the HPC ED in council activities; collaboration between the Council and the HPC's QIPP Committee to develop key questions and an analytic approach; HPC staff providing in-kind support to the Council.
Public forum for policy discussion	▪ Focused discussions and deliberations by the QIPP committee and other stakeholders and experts as appropriate on the challenges and opportunities for behavioral health integration; receive periodic updates on the progress of the HPC and by other state agencies in implementing key Chapter 224 strategies for advancing integration (i.e. the DOI/AGO on parity issues, DMH, and the Public Payer Reimbursement Commission.)

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Goals for our cost trends reports

The Commission releases an annual cost trends report, intended to provide:

- A profile of the Massachusetts health care delivery system
- An evidence-based discussion of trends in Massachusetts health care costs, leveraging new data sets such as the All-Payer Claims Database
- Analysis of drivers of growth, including factors leading the state's growth to be above or below the benchmark set by Chapter 224
- A fact base to inform the other activities of the Commission, as well as the broader policy discussion in Massachusetts
- Deep dives into specific cost drivers in Massachusetts, including:
  - Topics of known importance that can be addressed with new or state-specific data
  - Topics that have been insufficiently studied or evaluated
  - Topics where a comprehensive discussion integrating evidence from multiple sources can better inform policy dialogue

Findings from the 2013 cost trends report (1/2)

- Per capita spending in Massachusetts is the **highest of any state** in the U.S., crowding out other priorities for consumers, businesses, and government
  - Over the past decade, Massachusetts health care spending has **grown much faster than the national average**, driven primarily by faster growth in commercial prices
  - Massachusetts residents continue to **use health care services at a higher rate** than the nation, especially in **hospital care and long-term care**, although the difference between Massachusetts and the U.S. average has been stable over the past decade

- While **spending growth in Massachusetts since 2009** has slowed in line with slower national growth, sustaining lower growth rates will **require concentrated effort**
  - Past periods of slow health care growth in Massachusetts, such as the 1990s, have been followed by **sustained periods of higher growth**
  - While observed growth rates for individual payers are low, the statewide growth rate is higher, **driven by enrollment shifts among payers** due to trends such as the aging of the population

Findings from the 2013 cost trends report (2/2)

Hospital operating expenses

- The operating expenses that hospitals incur for inpatient care **differ by thousands of dollars per discharge**, even after adjusting for regional wages and complexity of care provided
- Some hospitals deliver **high-quality care with lower operating expenses**, while many higher-expense hospitals achieve lower quality performance
- Hospitals able to negotiate **high commercial rates have high operating expenses** and cover losses they experience on public payer business with income from their higher commercial revenue, while hospitals with more limited revenue must maintain lower operating expenses

Wasteful spending

- In 2012, an estimated **$14.7 to $26.9 billion (21 to 39 percent)** of health care expenditures in Massachusetts are estimated to be wasteful, reflecting both clinical and structural opportunities
- There are **opportunities to reduce wasteful spending** in preventable hospital readmissions, unnecessary emergency department visits, health care-associated infections, early elective inductions, and unnecessary imaging for lower back pain

High-cost patients

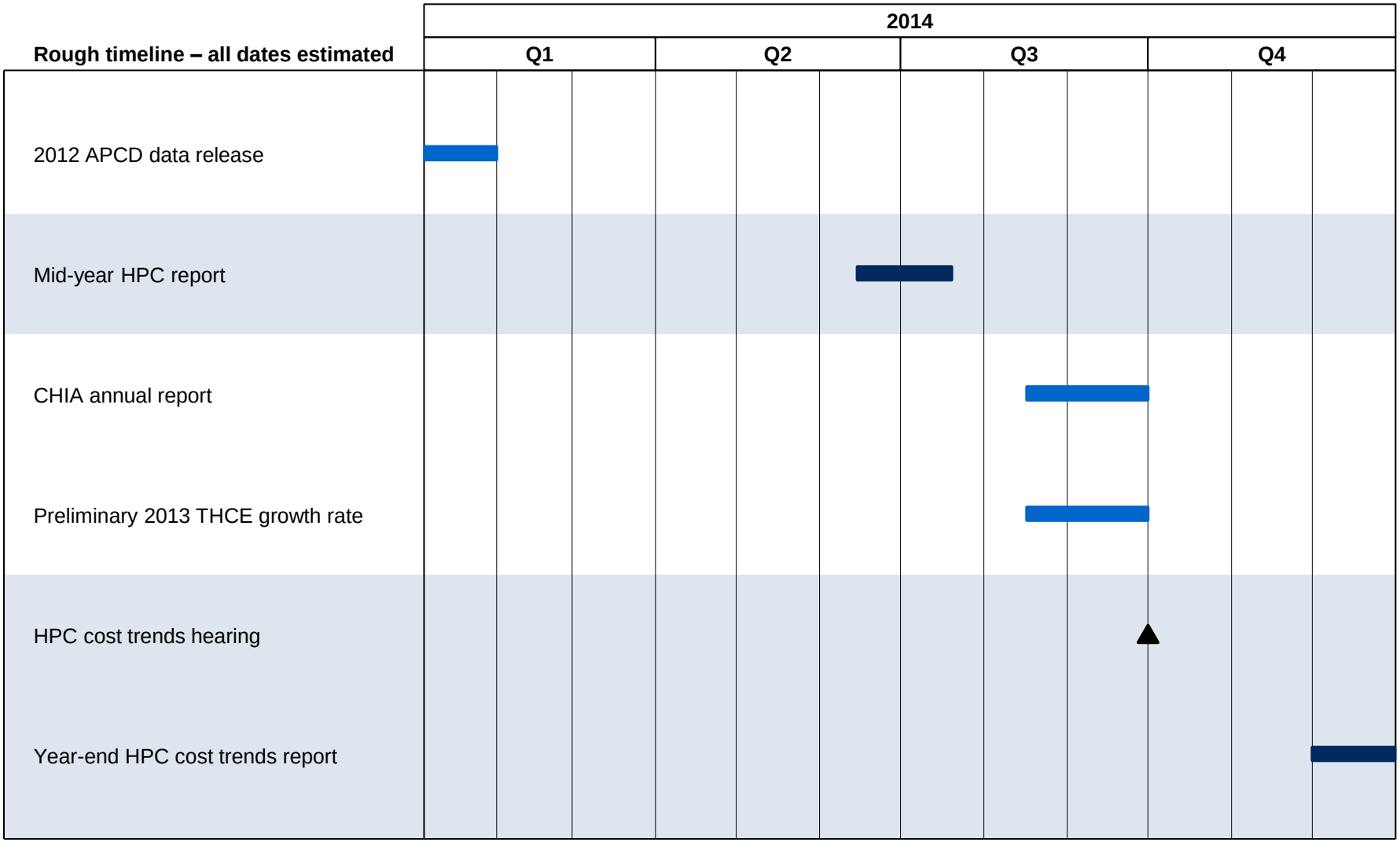
- In 2010, five percent of patients accounted **for nearly half of all spending** among both the Medicare and commercial populations in Massachusetts
- Certain characteristics differed between high-cost patients and the rest of the population:
  - A number of **conditions occurred more often** among high-cost patients, and high-cost patients generally had more clinical conditions than the rest of the population
  - The **interaction of conditions increased spending** more than the individual condition contributions
  - There is **modest regional variation** in the concentration of high-cost patients
  - **Lower-income zip codes** have a higher concentration of high-cost patients
- Persistently high-cost patients – those who remain high-cost in consecutive years – represent **29 percent of high-cost patients** and 15 to 20 percent of total spending

2013 report conclusion and action steps

We find that there are significant opportunities in Massachusetts to enhance the value of health care, addressing cost and quality. We identify four primary areas of opportunity for improving the health care system in Massachusetts:

1. **Fostering a value-based market** in which payers and providers openly compete to provide services and in which consumers and employers have the appropriate information and incentives to make high-value choices for their care and coverage options,
2. **Promoting an efficient, high-quality health care delivery system** in which providers efficiently deliver coordinated, patient-centered, high-quality health care that integrates behavioral and physical health and produces better outcomes and improved health status,
3. **Advancing alternative payment methods** that support and equitably reward providers for delivering high-quality care while holding them accountable for slowing future health care spending increases, and
4. **Enhancing transparency and data availability** necessary for providers, payers, purchasers, and policymakers to successfully implement reforms and evaluate performance over time.

Timeline for 2014



Preliminary 2014 research agenda extending from 2013 cost trends report

Basic profile	▪ Medicaid (payer) ▪ Long-term care and home health (service category) ▪ Behavioral health care (clinical area) ▪ Care for children (population segment) ▪ Disparities in access and care delivery ▪ Product design and trends
Hospital operating expenses	▪ Deepening analysis of particular areas of hospital expenses (e.g., capital expenses) ▪ Extending analysis to additional provider types
Wasteful spending	▪ Ongoing tracking of performance in reducing wasteful spending – Preventable readmissions – Unnecessary ED visits
High-cost patients	▪ Extending analysis to MassHealth population ▪ Identifying meaningful segments within high-cost patient population
Provider mix	▪ Profiling care provided in the Massachusetts market (discharges, episodes) ▪ Analysis of potential cost impact of provider mix changes for a common set of discharges and/or episodes

Discussion Questions: Annual Cost Trends Examination

- What are your general reactions to the HPC's October cost trends hearing and the 2013 cost trends report?
- How should the HPC follow up on the findings highlighted in the cost trends report, and which additional lines of research would be helpful in 2014?
- Are there additional analyses that the HPC should undertake that will enlighten our current understanding of health care cost trends and system transformation?
- What is your organization doing to address the findings highlighted in the cost trends report?

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CHART Phase 1 projects are underway

Phase 1 Status Report

- HPC staff have conducted site visits at **9 CHART hospitals**, with 2 scheduled in the coming months. Staff anticipate conducting site visits at all funded hospitals during Phase 1.
- Staff are conducting **regular monthly calls with CHART hospitals** for updates on milestones and project work, problem identification, and provision of limited technical assistance as needed.
- Phase 1 projects are generally **proceeding well**:
  - Where applicable, HPC staff are able to **coordinate efforts of teams** at different CHART hospitals engaged in similar efforts
  - Hospitals report **considerable excitement and enthusiasm** for CHART efforts
  - In some cases, projects are **delayed due to hiring challenges** or overly ambitious timeline
- Staff have **formalized the coordinating/oversight role of MeHI** for the six IT-heavy Phase 1 awards
- **Staff are engaged in ongoing coordination of CHART activities with key partners** *(e.g. Prevention and Wellness Trust Fund, Infrastructure and Capacity Building Grants, Workforce Development Trust, DSTI, MeHI e-Health investments, SIM, etc.)*

CHART Phase 1 Community Support

The Republican.

Western Massachusetts community hospitals receive $2 million in grants

"…at Holyoke Medical Center….switching to electronic records will make a big difference …'It's a very heavy, expensive endeavor. It's been in our budget to do for quite some time without the resources to do that." With the grant….'We will move full speed ahead to make it happen.'"

Gloucester Times

Aid for Addison Gilbert Hospital an ideal use for new state funding

"…the granting of this money to Addison Gilbert Hospital and other community hospitals that understandably face financial stresses is, in fact, an ideal use of money intended to better secure community hospital's future."

THE RECORDER

GREENFIELD, MASS. ESTABLISHED 1792. - N.E. NEWSPAPER OF THE YEAR 2012.

Hospital wins grant to increase tech-medicine

BOSTON BUSINESS JOURNAL

State doles out $10 million in 'Robin Hood' hospital funds

STATE HOUSE NEWS SERVICE

HPC awards $10M to community hospitals

The MILFORD DAILY NEWS

Milford Hospital receives $500K grant

Proposed CHART Phase 2 combines standardized aims with flexibility for hospitals approaches

Structure of tier(s) & caps	Funding model(s)
Specificity of project focus	Ensuring accountability

- Program focus on supporting achievement of **health care cost growth benchmark*)***
  - **Three standardized aims** drive deep impact across the Commonwealth, with flexibility of implementation approach and the overarching goal of transformation toward accountable care
  - Emphasis on **emerging technologies** to support achievement of aims
  - **Additional aim of strategic planning** to facilitate CHART hospitals' efforts to advance their ability to provide efficient, effective care and meet community needs in an evolving healthcare environment

3 +1+1

- Award sizes tied to factors such as **community need, hospital financial status, financial impact, and patient impact**, with payments tied to **milestones and outcomes**
- Proposals will include **mechanism** to address the aim, the **value proposition** to the hospital and to the Commonwealth, and **estimate of impact**. The detailed implementation work plan will be developed in the first 90-120 days
- **Standardized metrics** ensure accountability

Previous framing of goals for Phase 2 informed strategic process

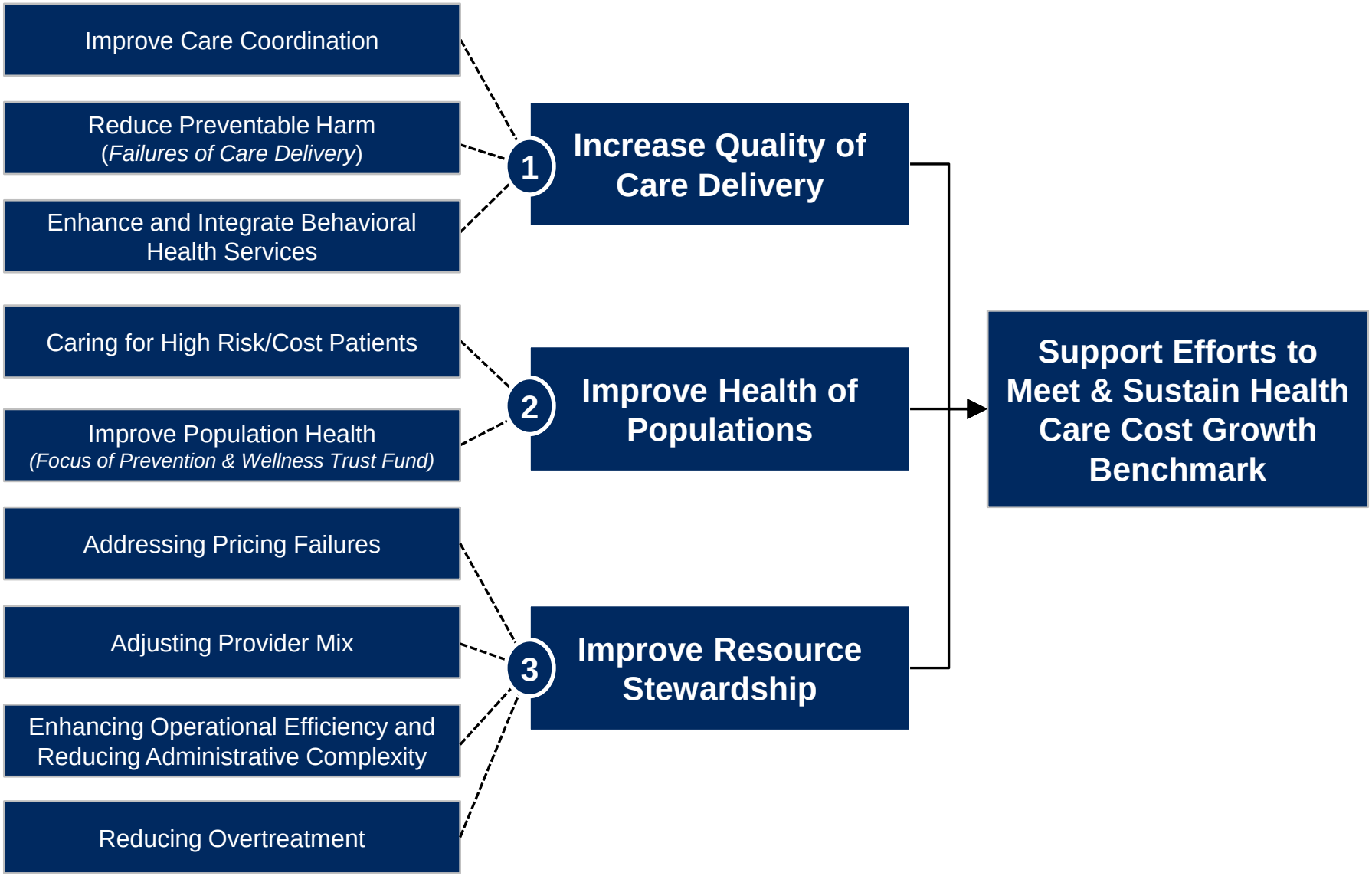


CHART Phase 2 development balances competing aims and pressures

Challenge	Proposed Approach
▪ Should CHART prioritize **evidence-based** established interventions or **innovative** emerging approaches?	▪ Staff propose a balanced approach with opportunities across the risk / impact spectrum
▪ How should CHART reconcile **broad statutory and regulatory goals** with the opportunity for focused, deep **impact**?	▪ To **maximize impact**, staff to propose a narrowed set of proposal aims for deep impact, only including aims likely to reduce healthcare cost growth.
▪ Should CHART require **standardization** of approaches to facilitate enhanced technical assistance and learnings between hospitals?	▪ CHART should balance a **standardization of aims** to maximize impact while **promoting hospital-specific mechanisms**/approaches to project implementation
▪ Should payments be based on **process** (protecting the financial health of CHART hospitals) or **outcomes** (providing the right incentives)?	▪ A **hybrid award and payment structure** shares risk between CHART program and hospitals, mindful of varied financial strength.
▪ How should CHART consider programs benefiting patients **today** that may not persist in the absence of **payment reform**?	▪ Consistent with goals of Chapter 224, Phase 2 pairs **care delivery reforms** that will be supported and enhanced by increased penetration of APMs with **process improvement and capacity development** that will maximize hospital efficiency and quality even in a FFS environment

In Proposed Phase 2 approach, hospitals propose mechanisms to meet specified aims, with the overarching goal to drive transformation toward accountable care

Support Achievement of Cost Growth Benchmark

Three outcome-based aims for implementation during 2-year grant period

Maximize appropriate hospital use	▪ Hot-spotting and population health management approaches to reduce acute care hospital utilization *(emergency department and inpatient)* ▪ Targeted reduction of readmissions after hospital -> SNF care transition ▪ Enhance discharge planning and emergency department interventions	
Hospital-wide process improvement	▪ Reduce costs through improved efficiency (e.g., Lean management applied on a system-wide basis) ▪ Improve safety and reliability of clinical processes (e.g., implementation of checklists) ▪ Reduce costs through improved financial management (e.g., cost accounting)	3
Enhancing behavioral health care	▪ Reduce emergency department boarding of patients with mental health and substance use disorders ▪ Integrate inpatient behavioral and physical health workflows ▪ Build hospital ←→ community networks for maximizing coordination of BH services	

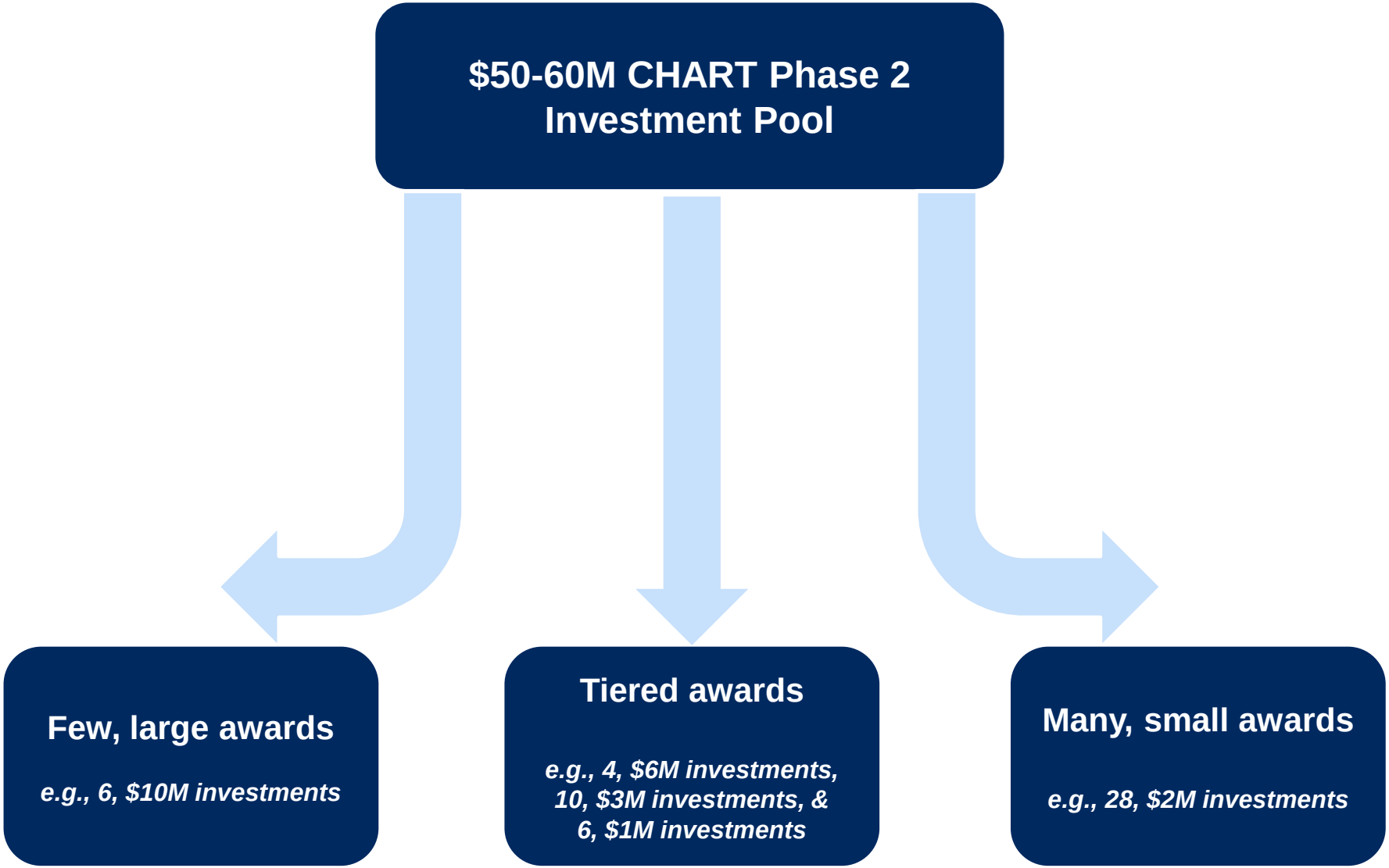
Focus on emerging technologies to enhance impact +

Connected health	▪ Connect to and use the Mass HIway *(required)* ▪ Increase specialty capacity at lower-cost sites of care through telemedicine to reduce preventable outmigration and maximize home-based care ▪ Use mobile technologies to facilitate achievement of outcome-based aims	1

One planning option, as a standalone grant or in conjunction with project tracks above +

Strategic planning	▪ CHART hospitals may propose efforts to engage in strategic and operational planning to advance their ability to provide efficient, effective care and meet community need in an evolving healthcare environment	1

Multiple potential models exist for spreading investments across CHART hospitals



Key decision points for CHART Phase 2

Size of total opportunity	▪ **$50-60 million** total opportunity ▪ Tiered award opportunities over **two years**
Structure of tier(s) & caps	▪ Award caps tied to factors such as **community need, hospital financial status, financial impact, and patient impact**
Specificity of project focus	▪ Three key project domains with a fourth area of innovation ▪ A fifth opportunity for applicants to engage in targeted planning efforts
Funding model(s)	▪ **Initiation** payment; ongoing base payments for **milestones**; bonus payments for **achievement** (e.g., process and outcomes)
Ensuring accountability	▪ **Standardized metrics** and streamlined reporting framework; strong continuation of **leadership/management** development focus
Leveraging partnerships	▪ Appropriate community **partnerships** required (e.g., SNFs, Community Based Organizations, other provider organizations, etc.)
Requisite Activities	▪ All awardees must engage in a series of **participation requirements** (e.g., joining Mass HIWay, etc.)

3 +1+1

Discussion Questions: CHART Investment Program

- What clinical or policy priorities should the HPC focus on and incentivize in the second round of CHART funding (Phase 2) (e.g., behavioral health, care coordination, waste reduction, connected health)?
- What funding models would you recommend the HPC use to guide Phase 2 investments (e.g., pay for performance, outcome-based payments, challenge grants)?
- What suggestions do you have for promoting CHART hospitals' connections to their communities in Phase 2 investments?
- How can the HPC best support or enhance learning and dissemination from CHART grant activity, both within cohort and broadly across all market participants?

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Discussion Questions: Public Engagement Effects

- What strategies would you recommend the HPC employ to enhance its engagement with various constituencies including providers, businesses, consumers, and the general public?
- What role do you think the Advisory Council should play in collaborating with the HPC on public engagement efforts? What are some specific opportunities for collaboration outreach and education efforts?
- What information or incentives do believe would be most helpful to consumers and employers in assisting them to make “high-value” choices for their care and coverage options?

Discussion Questions: Chapter 224 Implementation

- What aspects of the HPC's work are most important from your perspective?
- What activity of other state or federal agencies should the HPC be mindful of?
- What aspects of the HPC's work will have the greatest impact on our ability to meet our future health care cost growth goals?
- How can you or your organization assist the HPC in meeting its implementation timeline?

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Contact Information

For more information about the Health Policy Commission:

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